Information Release Form
(HIPPA Release Form)

Name:_____ Date of Birth _____

Release of Information

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

__Spouse _____
__Children_____
__Other_____
__ Information is not to be released to anyone.

The release of information will remain in effect until terminated in writing.

MESSAGES

Please call __my home __my cell __other
Number_____
___leave a message ___do not leave a message

Mercersburg Family Dentistry
200 Loudon Road, Mercersburg, Pa 17236
717-328-5700

Signed:_____ Date:_____
Witness:_____ Date:_____